# COMMONWEALTH of VIRGINIA

## *Department of Medical Assistance Services*

Dennis G. Smith
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4512 (Fax)
804/343-0634 (TDD)

December 17, 1999

Tim Westmoreland, Director
Center for Medicaid and State Operations
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Westmoreland:

We are requesting waivers under Section 1115 of the Social Security Act to allow Virginia to extend limited Medicaid eligibility for women whose pregnancy and delivery were paid by Medicaid to provide coverage for family planning services. This proposal was mandated in the last session of the General Assembly. A copy of the legislation is enclosed. This request is to waive sections 1902(a) 10(A), 1902(a) 10B and any other section necessary to implement the proposed waiver.

The population that this waiver would cover is those women whose pregnancy and delivery were paid by Medicaid and who would lose eligibility at the end of 60 days post partum and who would not be otherwise eligible. The proposed project would extend eligibility for family planning services to 24 months post delivery. The duration of the project would be five years. Virginia intends to demonstrate that extending family planning services will reduce Medicaid payments for unintended births and newborn care.

Thank you for your prompt attention to this waiver request. Per conversation with Alisa Adamo of your staff, we are including ten copies of the waiver request. Please contact Anita Cordill, Senior Policy Analyst, Division of Policy and Research, at 804-371-8855 for any additional information.

Sincerely,

/s/

Dennis G. Smith

DGS/ajc
Enclosure
Cc: Alisa Adamo
Michael Cruse

03j:anita\projects\fpwaiverCOltr

# EXTENDING MEDICAID FAMILY PLANNING BENEFITS FOR POSTPARTUM WOMEN

*A waiver request submitted under the Authority of Section 1115A Of the Social Security Act to the Health Care Financing Administration US Department of Health and Human Services*

STATE OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

TABLE OF CONTENTS

# PROPOSED EXTENSION OF FAMILY PLANNING BENEFITS FOR POSTPARTUM WOMEN

## INTRODUCTION

The Virginia Department of Medical Assistance Services is requesting a 1115 waiver fi-om the Health Care Financing Administration (HFCA) to extend eligibility for family planning services to women who received Medicaid for prenatal care and delivery services. The family planning services will extend fi-om the usual eligibility period that normally ends at 60 days postpartum, until twenty-four months fi-om the date of delivery. The women must continue to meet the financial eligibility requirements for a pregnant woman under Virginia Medicaid.

Family planning services include medically necessary services and supplies related to birth control and pregnancy prevention. Services include a variety of methods of family planning, patient education, counseling and referral as needed to other services. These services do not and shall not include payment to perform, assist, encourage or make direct referrals for abortion.

Virginia Medicaid provides coverage for pregnant women and infants at 133% of the federal poverty level. The women are only eligible for Medicaid benefits for *60* days postpartum. After 60 days, women whose incomes exceed the categorical limits for Medicaid lose eligibility for all benefits, including family planning.

If granted, this waiver would allow extension of Medicaid eligibility for family planning services for two years postpartum for these women who would otherwise lose eligibility, The impact of this project would be to prevent some unintended pregnancies, to increase the spacing between births, and improve pregnancy outcomes. The project also assumes a decrease in the cost of Medicaid paid pregnancy and delivery as well as the cost of the infant health care. The latter is important since most infants do not lose eligibility at the same time as the mother.

The implementation of the project would be within 90 days of receipt of approval fi-om HCFA. The requested duration of the project would be for *5* years in order to determine the success of the project. Annual analysis of data would be conducted to ensure that the expected objectives were being met.

PROPOSED EXTENSION OF FAMILY PLANNING BENEFITS
FOR **POSTPARTUM** WOMEN

## OBJECTIVES

- Improve access to and utilization of family planning services by women of childbearing age for whom pregnancy and delivery were paid by Medicaid.
- Decrease the number of Medicaid paid pregnancy and deliveries, which will also reduce annual expenditures for prenatal care, delivery and newborn and infant care.
- Improve the health of women by improved spacing of pregnancy and reducing unintended pregnancies.
- Improve birth outcomes by increasing the spacing between pregnancies.
- Reduce expenditures for low birth weight, congenital anomalies and neonatal intensive care.
- Reduce teen pregnancy rates by reducing repeat pregnancies.
- Reduction in abortions.
- Estimate the overall savings to Medicaid attributable to providing family planning services for two years postpartum.

PROPOSED EXTENSION OF FAMILY PLANNING BENEFITS
FOR POSTPARTUM WOMEN

## BACKGROUND

Public funding for family planning comes from the joint federal-state Medicaid program, Title X of the Public Health Service Act, as well as state and local funding. Medicaid prohibits imposing co-payments or deductibles, requires freedom of choice of providers even in managed care programs and the federal match is 90%. Title X provides free services to women with incomes of less that 100% of the poverty level and services to women with a sliding fee with incomes at 100%-250% of the poverty level, women above 250% of the poverty level are charged the full fee. In Virginia, Title X served **76,703** people for family planning services in 1998, an estimated **10%** were Medicaid.

### Literature Review

*The Best Intentions: Unintended Pregnancy and the Well Being of Children and Families,* an IOM publication reviewed the literature on the effects of unintended pregnancies. With an unintended pregnancy, the mother is more likely to seek prenatal care after the first trimester or not to obtain care at all. She is more likely to expose the fetus to harmful substances such as tobacco or alcohol. The child is at greater risk of low birth weight, of dying in its first year of life, of being abused and of not receiving sufficient resources for health development. The mother may be at greater risk of physical abuse. About one half of all unintended pregnancies end in abortion. Teenagers who have babies are less likely to complete school, more likely to be single parents and more likely to have larger families. Because of this, teenage mothers acquire less work experience, have lower earnings and are more likely to live in poverty. There is also a strong association with a teen mother being on welfare. Closely spaced pregnancy puts the infant at risk of pre-term delivery and low birth weight. There is also a link between unintended pregnancy and infant mortality.

The Alan Guttmacher Institute, a non-profit corporation for Reproductive Health Research, Policy Analysis and Public Education researches, tracks, analyzes and publishes information regarding reproductive issues, including family planning. The discussion below is from various publications issued by the Institute.

PROPOSED EXTENSION OF FAMILY PLANNING BENEFITS
FQR POSTPARTUM WOMEN

According to a ***January 1998 Facts in Brief: Contraceptive Services,*** every tax dollar spent for contraceptive services saves an average of **$3.00** in Medicaid costs for pregnancy related health care and medical care for newborns. According to this same issue, an estimated **25%** of women served by publicly funded clinics for family planning services are Medicaid eligible.

***Issues in Brief. 1999 Series, No. 2. U.S. Policy Can Reduce Cost Barriers to Contraception.*** In Indemnity health care plans, 50% do not cover any form of reversible contraception, **33%** cover oral contraceptives, and only **15%** cover **all** five prescriptive methods-the pill, IUD, diaphragm, implants and injectables. Of HMOs, **39%** cover the five prescriptive methods, and **7%** do not cover prescriptions. Nine of **10** plans of all types cover sterilization and two-thirds provide abortion coverage. Benefits of expanded Medicaid eligibility have already been demonstrated in Rhode Island. The number of women having Medicaid-funded deliveries who became pregnant within nine months of a previous birth fell by almost 50% in the first three years of the program. The state estimates that it spent **$5.7** million on family planning between **1994** and **1997** and saved **$14.3** million in costs related to deliveries and newborn care.

***Facts In Brief, January 1998, Contraception Counts: Virginia Information.*** (Data from **1994-95**) Each year in Virginia **102** pregnancies per 1,000 women aged **15-44** occur, **61%** result in live births and **24%** in abortions. There are **101** pregnancies annually per 1,000 women aged **15-19** in Virginia, **24*** nationally, with **51%** resulting in live births and **35%** resulting in abortion, In Virginia, **29%** of all births are to unmarried women, ***An*** estimated **841**,080 women in Virginia, including **125,950** teenagers who may seek contraceptives. In Virginia, **12%** of women aged **15-44** are living in poverty, and **15%** do not have private health insurance or Medicaid. This means that in Virginia, **386,690** women aged **13-44,** including **125,950** teenagers may seek publicly supported contraceptive services if offered. Virginia ranks **40*** in the United States in the provision of contraceptive services to women in need. While the 195 publicly supported family planning clinics in Virginia serve 13**5,480** women, including 33, 750 teenagers, this represents only **35% of** all women in need and **27%** of teenagers in need. It is estimated that the publicly supported contraceptive services in Virginia avert **31,600** pregnancies-unwanted births, abortions and miscarriages each year.

***Issues In Brief, January 1998, Contraception Counts: State-by State Information*** Nearly half of the 6.3 million pregnancies in the United States per year are unintended. Most women in the fertile age range use a contraceptive method, only 10% are nonusers. However, those women who do not use a contraceptive method have 47% of the unintended pregnancies annually. Among the women who do not use a contraceptive, 44% of the pregnancies end in a live birth, 43% end in abortion and 13% end in a miscarriage.

The CDC February 12,1999 MMWR Weekly article entitled Insurance Coverage of Unintended Pregnancies Resulting in Live-Born Infants – Florida, Georgia, Oklahoma, and South Carolina, 1996 discussed data from the Pregnancy Risk Assessment and Monitoring System (PRAMS). The report indicates that the highest rates of unintended pregnancy in these four states occurred among women covered by Medicaid, with a range of 58.9% to 65.3%. The prevalence of unintended pregnancy among women delivering live-born infants was higher among unmarried women, black women, and women whose prenatal care was paid by Medicaid.

Virginia Data

In the latest year that state data is available, there were an estimated 1,549,105 women of child bearing age (15-44) in Virginia. There were 125,071 total pregnancies resulting in 91,664 live births and 25,875 induced terminations. There were 7,081 infants born at low birth weight and 1,151 with congenital anomalies. (Virginia Health Statistics-1997)

In the Medicaid program for 1997, there were 151,600 women of child bearing age. There were 30,486 pregnancies, 23,633 of those pregnancies were women eligible for Medicaid only because they were pregnant. There were 59 abortions paid through the Department, 51 with state only funds. Generally, infants born to Medicaid women remain eligible for up to one year. There were 38,926 children under one year of age accounting for $82,133,784 Medicaid expenditures. There were 24,359 women who received family planning services with expenditures of $2,419,492.

PROPOSED EXTENSION OF FAMILY PLANNING BENEFITS
FOR POSTPARTUM WOMEN

## TARGET POPULATION

This project would extend Medicaid coverage of family planning services for **24** months to postpartum women:

1. Who have given birth during the period beginning with the implementation of the project in mid 1999 to the end of the project five years hence; and
2. Whose deliveries were covered by Medicaid; and
3. Who continue to meet Medicaid eligibility income requirements for a pregnant woman.

## SERVICES PROVIDED

Services available under the project would include:

Family Planning Office visits
Laboratory for Family Planning only
Family planning education and counseling
**FDA** approved contraceptives
Over the counter contraceptives
Diaphragms
Contraceptive Injectables
Contraceptive Implants
Sterilizations
Hysterectomies

Services do not include infertility treatments, or counseling, recommendations or performance of abortions.

PROPOSED EXTENSION OF FAMILY PLANNING BENEFITS
FOR POSTPARTUM WOMEN

## SERVICE DELIVERY

Women eligible for family planning services under this project would continue to have freedom of choice in providers. The services would be reimbursed on a fee for service basis. Participation in the PCCM program, MEDALLION or the mandatory managed care program, Medallion II would not be required since the only services for which these women will be eligible is family planning.

## ELIGIBILITY AND DURATION

Eligibility will be re-determined by the Virginia Department of Social Services (DSS) at *60* days postpartum. Women are notified at 60 days postpartum that their Medicaid benefits are terminated. The notice includes notification of the need to re-determine eligibility for continued benefits. If a recipient of the target population is not eligible for full Medicaid coverage through another eligibility category, she will be screened for eligibility for Medicaid coverage for family planning services. The women would be notified that she is not eligible for full Medicaid coverage but only for family planning services. She would be identified with a special program designation code and issued a special Medicaid card that clearly identifies her as a recipient for family planning services only. The woman would be informed that she must provide information to DSS regarding any change in circumstances. Eligibility would be re-determined 12 months later by DSS. If the woman continues to meet the eligibility requirements for the family planning services, eligibility would continue until **24** months post delivery. If at eligibility re-determination or at any point a self reported change in circumstance results in categorical eligibility for full Medicaid benefits, enrollment in the waiver services would be discontinued.

## PUBLIC AWARENESS AND OUTREACH

DSS would include information regarding this project in all Medicaid correspondence, pamphlets, etc. The Medicaid recipient handbook, which includes descriptions of all services, would include information regarding the extended family planning benefits. Information would be available to recipients and providers on the DMAS web site. Brochures or fliers would be developed and made available in Physician offices and in hospitals. Medicaid PCCM and managed care organizations would be required to inform pregnant women of the extended services. The Baby Care program, a Medicaid program that provides Case Management to high risk pregnant women and infants would provide outreach for these services. The Virginia Department of Health would be provided with the fliers for outreach purposes within their clinics, including family planning clinics, through the Healthy Start Program and the Title V, Children with Special Health Care Needs program. Also, information would be made available through the Early Intervention Program for Infants and Toddlers with Disabilities. Virginia Medicaid provides administrative funds to the Virginia Department of Health for two programs, a maternal outreach program know as Resource Mothers and a Teen Pregnancy Prevention project. The coordinators of those projects at the local level would also provide outreach for the expanded family planning services. **All** information would include clear information that the only service available under the waiver **is** family planning services. It must be very clear to enrollees that there is no other Medicaid services available.

## EVALUATION

***An*** evaluation will be conducted internally by review of claims data to determine the progress of the project. The agency is currently in the process of establishing a baseline data base from FY **93** through FY **99** claims history. Data that will be tracked: Medicaid paid pregnancy, delivery, repeat pregnancies with intervals, infant care including low **birth** weight, neonatal intensive care, congenital anomalies **as** well **as** methods and costs of family planning. Where possible, comparison to state vital statistics will be made. Fee for service data will be tracked separately from the data from managed care organizations. Both data sets will be adjusted as necessary for increase or decline in total Medicaid population. In the final year of the project an evaluation will be performed under **an** Interagency Agreement with the research department of one of Virginia's universities. The methodology for the study will be developed with the University. The evaluation would include:

- Was there a reduction in the total number of pregnancies and deliveries paid by Medicaid?
- Are women utilizing the expanded family planning services?
- Did women who received the expanded family planning have an additional delivery paid by Medicaid?
- If there were additional pregnancies for the women receiving expanded family planning services, was there a two-year spacing between pregnancies?
- **Was** there a change in birth outcomes as evidenced by newborn and infant care costs?
- **Was** there an over all cost savings to the Medicaid Program?

## **MMIS SYSTEM** CHANGES

The **MMIS** system would be modified to include edits linking the established program designation code to the family planning services billing codes to ensure only family planning services are reimbursed for these women. An edit would be in place to terminate eligibility at **24** months postpartum. The system edits related to third party payments would apply. There would also be edits to prohibit co-existing program designations for the same woman.

## WAIVERS

Virginia requests the following waivers

- ***Eligibility.*** Section 1902(a) 10(A) and the implementing regulations of 42CFR **Part** 435 in order to extend family planning services to individuals who meet pregnancy income requirements and have had a Medicaid reimbursed delivery, regardless of whether they satisfy the optional or mandatory categories of eligibility.
- ***Amount, Duration and Scope of Services.*** Section 1902(a) 10(B) and 42 CFR, ss.440.230-250, require that the amount, duration, and scope of services be available equally to all recipients within an eligibility category and be available equally to categorically eligible recipients and Medically Needy recipients. The amount, duration and scope of services for women receiving extended family planning services will vary from those available to recipients enrolled in traditional eligibility categories. Section 1902(a) 10 and 42 CFR, ss 441.10-62 contain minimum requirements for Medicaid benefits. A waiver of the minimum benefits is required for extended family planning service recipients, who will not be eligible for other benefits covered in the traditional Medicaid eligibility categories.
- ***Other*** Virginia requests that the HCFA grant any other waiver necessary to implement extended family services for women who meet the eligibility requirements described in this application.

## REFERENCES

The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families. (1995). Institute of Medicine, National Academy Press. Washington, DC.

Contraceptive Services. Facts In Brief. (1998). The Alan Guttmacher Institute. New York and Washington.

**U.S.** Policy Can Reduce Cost Barriers to Contraception. Issues in Brief No.2 (1999). The Alan Guttmacher Institute. New York and Washington.

Contraception Counts: Virginia Information. Facts In Brief. (1998). The Alan Guttmacher Institute. New York and Washington.

Contraception Counts: State-by State Information. . Issues in Brief. (1998). The Alan Guttmacher Institute. New York and Washington.

Insurance Coverage of Unintended Pregnancies Resulting in Live-Born Infants--Florida, Georgia, Oklahoma, and South Carolina, 1996. CDC-MMWR 1999, 48(05), pp.100-104.

The Statistical Record of the Virginia Medicaid Program-State Fiscal Year 1997. Department of Medical Assistance Services. Richmond, Virginia.

Virginia Health Statistics. (1997). Virginia Department of Health, Center for Health Statistics. Richmond, Virginia.

ATTACHMENT 1 - FAMILY PLANNING WAIVER BUDGET NEUTRALITY WORKSHEET

| TOTAL COSTS | | SFY 2000 | SFY 2001 | SFY 2002 | SFY 2003 | SFY 2004 | TOTAL |
|---|---|---|---|---|---|---|---|
| **WITHOUT WAIVER** | | | | | | | |
| FAMILY PLANNING SERVICES_1 | Persons | 35,119 | 33,573 | 33,573 | 33,573 | 33,573 | |
| (Recipients) | Per Capita | $263 | $287 | $287 | $287 | $287 | |
| | Total | $9,231,578 | $9,619,304 | $9,619,304 | $9,619,304 | $9,619,304 | $47,708,796 |
| TOTAL DELIVERY, INFANT, NEWBORN CARE COSTS_2 | Persons | 17,837 | 16,963 | 16,963 | 16,963 | 16,963 | |
| | Per Capita | $7,251 | $7,251 | $7,251 | $7,251 | $7,251 | |
| | Total | $129,335,768 | $122,998,315 | $122,998,315 | $122,998,315 | $122,998,315 | $621,329,029 |
| TOTAL WITHOUT-WAIVER COSTS | | $138,567,346 | $132,617,620 | $132,617,620 | $132,617,620 | $132,617,620 | $669,037,825 |
| **WITH WAIVER** | | | | | | | |
| FAMILY PLANNING SERVICES_3 | Persons | 36,875 | 36,931 | 36,931 | 36,931 | 36,931 | |
| | Per Capita | $263 | $287 | $287 | $287 | $287 | |
| | Total | $9,693,157.07 | 10,581,234.89 | $10,581,234.89 | $10,581,234.89 | $10,581,234.89 | $52,018,097 |
| TOTAL DELIVERY, INFANT, NEWBORN CARE COSTS_4 | Persons | 17,248 | 15,826 | 15,826 | 15,826 | 15,826 | |
| | Per Capita | $7,251 | $7,251 | $7,251 | $7,251 | $7,251 | |
| | Total | $125,067,688 | $114,757,428 | $114,757,428 | $114,757,428 | $114,757,428 | $584,097,400 |
| SYSTEM CHANGES | | $100,000 | | | | | |
| EVALUATION | | | | | $100,000 | | |
| Administrative Costs-(eligibility, public awareness, etc) | | $20,000 | $20,000 | $20,000 | $20,000 | $20,000 | $100,000 |
| TOTAL WITH WAIVER COSTS | | $134,880,845 | $125,358,663 | $125,358,663 | $125,458,663 | $125,358,663 | $636,215,497 |
| DIFFERENCE | | ($3,600,501) | -$7,258,957 | -$7,258,957 | -$7,158,957 | -$7,258,957 | -$32,822,328 |

_1 Includes recipients who received family planning and sterilization services in FY 1999. To compute the number of recipients and costs in FY 2000 and FY 2001, annual growth rates of -4.6 and 4.2% were used, respectively. The recipients in managed care plans were also included in the calculations.

_2 The number of deliveries include women in the Medicaid Fee-For-Service and managed care programs for FY 1999. A growth rate of -4.9% was used to compute the number of deliveries for FY2000. An average maternity/newborn cost of $7,251 was was multiplied by the estimated number of deliveries to derive total delivery and infant newborn care costs.

_3 It is expected that the number of recipients using family planning services in the wavier progam will increase by 5% in FY2000 and 10% there after.

_4 According to a study by Tompkins, 1986, one pregnancy is averted for every 15 women who seek family planning services. For the estimate of deliveries in SFY 2000, this factor was divided by 2.

ATTACHMENT 2 - FAMILY PLANNING WAIVER BUDGET NEUTRALITY WORKSHEET

| FEDERAL COSTS | | SFY 2000 | SFY 2001 | SFY 2002 | SFY 2003 | SFY 2004 | TOTAL |
|---|---|---|---|---|---|---|---|
| **WITHOUT WAIVER** | | | | | | | |
| FAMILY PLANNING SERVICES_1 | Persons | 35,119 | 33,573 | 33,573 | 33,573 | 33,573 | |
| (Recipients) | Per Capita | $237 | $258 | $258 | $258 | $258 | |
| | Total | $8,308,420 | $8,657,374 | $8,657,374 | $8,657,374 | $8,657,374 | $42,937,916 |
| TOTAL DELIVERY, INFANT, NEWBORN CARE COSTS_2 | Persons | 17,837 | 16,963 | 16,963 | 16,963 | 16,963 | |
| | Per Capita | $7,251 | $7,251 | $7,251 | $7,251 | $7,251 | |
| | Total | $66,737,256.27 | $63,467,130.71 | $63,467,130.71 | $63,467,130.71 | $63,467,130.71 | $320,605,779 |
| TOTAL WITHOUT-WAIVER COSTS | | $75,045,677 | $72,124,505 | $72,124,505 | $72,124,505 | $72,124,505 | $363,543,695 |
| **WITH WAIVER** | | | | | | | |
| FAMILY PLANNING SERVICES_1 | Persons | 36,875 | 36,931 | 36,931 | 36,931 | 36,931 | |
| | Per Capita | $237 | $258 | $258 | $258 | $258 | |
| | Total | $8,723,841.36 | $9,523,111.40 | $9,523,111.40 | $9,523,111.40 | $9,523,111.40 | $46,816,287 |
| TOTAL DELIVERY, INFANT, NEWBORN CARE COSTS_2 | Persons | 17,248 | 15,826 | 15,826 | 15,826 | 15,826 | |
| | Per Capita | $7,251 | $7,251 | $7,251 | $7,251 | $7,251 | |
| | Total | $64,534,927 | $59,214,833 | $59,214,833 | $59,214,833 | $59,214,833 | $301,394,259 |
| SYSTEM CHANGES | | $51,600 | | | | | |
| EVALUATION | | | | | $51,600 | | |
| Administration (eligibility, public awareness) | | $10,320 | $10,320 | $10,320 | $10,320 | $10,320 | $51,600 |
| TOTAL WITH WAIVER COSTS | | $73,320,688 | $68,748,264 | $68,748,264 | $68,799,864 | $68,748,264 | $348,262,146 |
| DIFFERENCE | | -$1,724,988 | -$3,376,240 | -$3,376,240 | -$3,324,640 | -$3,376,240 | -$15,281,550 |

_1 The Federal share of total Familiy Planning expenditures is 90%.
_2 The Federal share of medical expenditures is 51.6%.

ATTACHMENT 3 - FAMILY PLANNING WAIVER BUDGET NEUTRALITY WORKSHEET

| STATE COSTS | | SFY 2000 | SFY 2001 | SFY 2002 | SFY 2003 | SFY 2004 | TOTAL |
|---|---|---|---|---|---|---|---|
| WITHOUT WAIVER | | | | | | | |
| FAMILY PLANNING SERVICES_1 | Persons | 35,119 | 33,573 | 33,573 | 33,573 | 33,573 | |
| (Recipients) | Per Capita | $26 | $29 | $29 | $29 | $29 | |
| | Total | $923,158 | $961,930 | $961,930 | $961,930 | $961,930 | $4,770,880 |
| TOTAL DELIVERY, INFANT, NEWBORN CARE COSTS_2 | Persons | 17,837 | 16,963 | 16,963 | 16,963 | 16,963 | |
| | Per Capita | $7,251 | $7,251 | $7,251 | $7,251 | $7,251 | |
| | Total | $62,598,511.69 | $59,531,184.62 | $59,531,184.62 | $59,531,184.62 | $59,531,184.62 | $300,723,250 |
| TOTAL WITHOUT-WAIVER COSTS | | $63,521,670 | $60,493,115 | $60,493,115 | $60,493,115 | $60,493,115 | $305,494,130 |
| WITH WAIVER | | | | | | | |
| FAMILY PLANNING SERVICES_1 | Persons | 36,875 | 36,931 | 36,931 | 36,931 | 36,931 | |
| | Per Capita | $26 | $29 | $29 | $29 | $29 | |
| | Total | $969,315.71 | $1,058,123.49 | $1,058,123.49 | $1,058,123.49 | $1,058,123.49 | |
| TOTAL DELIVERY, INFANT, NEWBORN CARE COSTS_2 | Persons | 17,248 | 15,826 | 15,826 | 15,826 | 15,826 | |
| | Per Capita | $7,251 | $7,251 | $7,251 | $7,251 | $7,251 | |
| | Total | $60,532,760.80 | $55,542,595.25 | $55,542,595.25 | $55,542,595.25 | $55,542,595.25 | $282,703,142 |
| SYSTEM CHANGES | | $48,400 | | | | | |
| EVALUATION | | | | | $48,400 | | |
| Administrative (eligibility, public aware ss etc) | | $9,680 | $9,680 | $9,680 | $9,680 | $9,680 | $48,400 |
| TOTAL WITH WAIVER COSTS | | $61,560,157 | $56,610,399 | $56,610,399 | $56,658,799 | $56,610,399 | $287,953,351 |
| DIFFERENCE | | -$1,961,513 | -$3,882,716 | -$3,882,716 | -$3,834,316 | -$3,882,716 | -$17,540,778 |

_1 The State share of total Familiy Planning expenditures is 10%.

_2 The State share of medical expenditures is 48.4%.

# ATTACHMENT 4
**Applicable pages 3 and 7**

summary | pdf

**CHAPTER 1024**

***An Act to amend and reenact §§ 11-45, 32.1-325, and 32.1-325.1:1 of the Code of Virginia, relating to medical assistance services.***

27171
Approved April 7,1999

Be it enacted by the General Assembly of Virginia:

1. That §§ 11-45, 32.1-325, and 32.1-325.1:1 of the Code of Virginia are amended and reenacted as follows:

§ 11-45. Exceptions to requirement for competitive procurement.

A. Any public body may enter into contracts without competition for the purchase of goods or services (i) which are performed or produced by persons, or in schools or workshops, under the supervision of the Virginia Department for the Visually Handicapped; or (ii) which are performed or produced by nonprofit sheltered workshops or other nonprofit organizations which offer transitional or supported employment services serving the handicapped.

B. Any public body may enter into contracts without competition for (i) legal services, provided that the pertinent provisions of Chapter 11 (§ 2.1-117 et seq.) of Title 2.1 remain applicable; or (ii) expert witnesses and other services associated with litigation or regulatory proceedings.

C. Any public body may extend the term of an existing contract for services to allow completion of any work undertaken but not completed during the original term of the contract.

D. An industrial development authority may enter into contracts without competition with respect to any item of cost of "authority facilities" or "facilities" as defined in § 15.2-4902.

E. The Department of Alcoholic Beverage Control may procure alcoholic beverages without competitive sealed bidding or competitive negotiation.

F. Any public body administering public assistance programs as defined in § 63.1-87, the fuel assistance program, community services boards as defined in § 37.1-1, or any public body purchasing services under the Comprehensive Services Act for At-Risk Youth and Families (§ 2.1-745 et seq.) may procure goods or personal services for direct use by the recipients of such programs without competitive sealed bidding or competitive negotiations if the procurement is made for an individual recipient. Contracts for the bulk procurement of goods or services for the use of recipients shall not be exempted from the requirements of § 11-41.

G. Any public body may enter into contracts without competitive sealed bidding or competitive negotiation for insurance if purchased through an association of which it is a member if the association was formed and is maintained for the purpose of promoting the interest and welfare of and developing close relationships with similar public bodies, provided such association has procured the insurance by use of competitive principles and provided that the public body has made a determination in advance after reasonable notice to the public and set forth in writing that competitive sealed bidding and competitive negotiation are not fiscally advantageous to the public. The writing shall document the basis for this determination.

H. The Department of Health may enter into contracts with laboratories providing cytology and related services without competitive sealed bidding or competitive negotiation if competitive sealed bidding and competitive negotiations are not fiscally advantageous to the public to provide quality control as prescribed in writing by the Commissioner of Health.

I. The Director of the Department of Medical Assistance Services may enter into contracts without

competitive sealed bidding or competitive negotiation for special services provided for eligible recipients pursuant to § 32.1-3254 *H*, provided that the Director has made a determination in advance after reasonable notice to the public and set forth in writing that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public, or would constitute an imminent threat to the health or welfare of such recipients. The writing shall document the basis for this determination.

J. The Virginia Code Commission may enter into contracts without competitive sealed bidding or competitive negotiation when procuring the services of a publisher, pursuant to §§ 9-77.7 and 9-77.8, to publish the Code of Virginia or the Virginia Administrative Code.

K. effective until July 1, 1999) The State Health Commissioner may enter into agreements or contracts without competitive sealed bidding or competitive negotiation for the compilation, storage, analysis, evaluation, and publication of certain data submitted by health care providers and for the development of a methodology to measure the efficiency and productivity of health care providers pursuant to Chapter 7.2 (§ 32.1-276.2 et seq.) of Title 32.1, if the Commissioner has made a determination in advance, after reasonable notice to the public and set forth in writing, that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public. The writing shall document the basis for this determination. Such agreements and contracts shall be based on competitive principles.

L. A community development authority formed pursuant to Article 6 (§ 15.2-5152 et seq.) of Chapter 51 of Title 15.2, with members selected pursuant to such article, may enter into contracts without competition with respect to the exercise of any of its powers permitted by § 15.2-5158; however, this exception shall not apply in cases where any public funds other than special assessments and incremental real property taxes levied pursuant to § 15.2-5158 are used as payment for such contract.

M. Virginia Correctional Enterprises may enter into contracts without competitive sealed bidding or competitive negotiation when procuring materials, supplies, or services for use in and support of its production facilities, provided such procurement is accomplished using procedures which ensure the efficient use of funds as practicable and, at a minimum, shall include obtaining telephone quotations. Such procedures shall require documentation of the basis for awarding contracts under this section.

N. The Virginia Baseball Stadium Authority may enter into agreements or contracts without competitive sealed bidding or competitive negotiation for the operation of any facilities developed under the provisions of Chapter 58 (§ 15.2-5800 et seq.) of Title 15.2, including contracts or agreements with respect to the sale of food, beverages and souvenirs at such facilities.

O. The Department of Health may procure child restraint devices, pursuant to § 46.2-1097, without competitive sealed bidding or competitive negotiation.

P. With the consent of the Governor, the Jamestown-Yorktown Foundation may enter into agreements or contracts with private entities without competitive sealed bidding or competitive negotiation for the promotion of tourism through marketing provided a demonstrable cost savings, as reviewed by the Secretary of Education, can be realized by the Foundation and such agreements or contracts are based on competitive principles.

Q. The Virginia Racing Commission may designate an entity to administer and promote the Virginia Breeders Fund created pursuant to § 59.1-372.

R. The Chesapeake Hospital Authority may enter into contracts without competitive sealed bidding or competitive negotiation in the exercise of any power conferred under Chapter 271, as amended, of the Acts of Assembly of 1966.

S. The Hospital Authority of Norfolk may enter into contracts without competitive sealed bidding or competitive negotiation in the exercise of any power conferred under Chapter 53 (§ 15.2-5300 et seq.) of Title 15.2. The Authority shall not discriminate against any person on the basis of race, color, religion, national origin, sex, pregnancy, childbirth or related medical conditions, age, marital status, or disability

in the procurement of goods and services.

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $2,500 for the individual and an amount not in excess of $2,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

***7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of twenty-four months if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid.***

***For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;***

~~7.~~ 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma or breast cancer and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

~~8.~~ *9.* **A** provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

~~9.~~ *10.* A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

~~10.~~ *11.* A provision for payment of medical assistance for annual pap smears;

~~11.~~ ***12.*** A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

~~12.~~ *13.* A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in **this** subdivision shall be construed **as** requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

~~13.~~ ***14.*** A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

~~14.~~ ***15.*** A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen; and

~~15.~~ *16.* A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

*B.* In preparing the plan, the Board shall:

1. **Work** cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. ~~The Board shall also~~ Initiate such cost containment or other measures **as** are set **forth** in the appropriation act.

3. ~~The Board may~~ Make, adopt, promulgate and enforce such regulations **as** may be necessary to carry

out the provisions of this chapter.

*4.* ~~Before the Board acts~~ ***Examine, before acting*** on a regulation to be published in the Virginia Register of Regulations pursuant to § 9-6.14:7.1 **,** ~~the Board shall examine~~ the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards **of** social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

~~5. The Board's regulations shall incorp~~ Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with **42** C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services **as** may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by **courts** of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of § 9-6.14:4.1 **,** (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

~~B.~~ *D.* The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and ~~to~~ receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; **and to** enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers **as** provided by law.

2. ~~C. The Director of Medical Assistance Services is authorized to~~ Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction **is** reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. ~~The Director may~~ Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

*4.* ~~In addition, the Director may~~ Refuse to enter into or renew **an** agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

*E.* In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

*F.* When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

~~D.~~ G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

~~E.~~ *H.* The Department shall include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

~~F.~~ *I.* The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

*J.* Except as provided in subsection I of § 11-45, the provisions of the Virginia Public Procurement Act (§ 11-35 et seq.) shall not apply to the activities of the Director authorized by ~~this~~ subsection *I of this section.* Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-325.1:1. Definitions; recovery of overpayment for medical assistance services.

A. For the purposes of this section, the following definitions shall apply:

"Agreement" means any contract executed for the delivery of services to recipients of medical assistance pursuant to ~~subsection C~~ *subdivision D 2* of § 32.1-325.

"Successor in interest" means any person as defined in § 1-13.19 having stockholders, directors, officers, or partners in common with a health care provider for which an agreement has been terminated.

"Termination" means (i) the cessation of operations by a provider, (ii) the sale or transfer of the provider, (iii) the reorganization or restructuring of the health care provider, or (iv) the termination of an agreement by either party.

B. The Director of Medical Assistance Services shall collect by any means available to him at law any amount owed to the Commonwealth because of overpayment for medical assistance services. Upon making an initial determination that an overpayment has been made to the provider pursuant to § 32.1-325.1, the Director shall notify the provider of the amount of the overpayment. Such initial determination shall be made within the earlier of (i) four years, or (ii) fifteen months after filing of the final cost report by the provider subsequent to sale of the facility or termination of the provider. The provider shall make arrangements satisfactory to the Director to repay the amount due. If the provider fails or refuses to make arrangements satisfactory to the Director for such repayment or fails or refuses

to repay the Commonwealth for the amount due for overpayment in a timely manner, the Director may devise a schedule for reducing the Medicaid reimbursement due to any successor in interest.

C. In any case in which the Director is unable to recover the amount due for overpayment pursuant to subsection B, he shall not enter into another agreement with the responsible provider or any person who is the transferee, assignee, or successor in interest to such provider unless (i) he receives satisfactory assurances of repayment of all amounts due or (ii) the agreement with the provider is necessary in order to ensure that Medicaid recipients have access to the covered services rendered by the provider.

Further, to the extent consistent with federal and state law, the Director shall not enter into any agreement with a provider having any stockholder possessing a material financial interest, partner, director, officer, or owner in common with a provider which has terminated a previous agreement for participation in the medical assistance services program without making satisfactory arrangements to repay all outstanding Medicaid overpayment.

D. The provisions of this section shall not apply to successors in interest with respect to transfer of a medical care facility pursuant to contracts entered into before February 1,1990.

2. That the provisions of this act shall not become effective until receipt of a Section 1115 waiver from the Health Care Financing Administration in the United States Department of Health and Human Services. The Department of Medical Assistance Services shall apply for such waiver as soon as possible, but not later than December 31,1999. If waiver approval is granted, implementation shall occur no later than three months following the date of the approval.

---

Go to (General Assembly Home)